INSTRUCTIONS FOR COMPLETING

MICHIGAN CLOSED CLAIM REPORTING FORM
FORM B

Form B
IBA-210 (8/86)

General Instructions.

Fill in the boxes completely using the appropriate number (i.e., 1 for Yes, 2 for No).

A. **IDENTIFICATION**

Defendant — Please place the hospital or defendants name and Michigan license number. Individual code numbers will be assigned by the Insurance Bureau to each hospital in the state. Use last name, first name, middle initial. Record whether the insured is the primary or secondary defendant.
Arbitration No. or Court No. & County — This is the number assigned by the Arbitration Association or Court docket number. Record the numbers as requested and in this way the Insurance Bureau will be able to cross-reference Form Bs submitted by different participating organizations for the same claim. County Codes are on the last page of this form.
Claimant's Name — Record last name first, space first name. A further cross-reference for statistical accuracy.

B. **COVERAGE**

HPL/PHY (Occurence) — Hospital Professional Liability/Physician Professional Liability — Occurence.
HPL/PHY (Claims-Made) — Hospital Professional Liability/Physician Professional Liability — Claims-Made.
HPL Self-Ins. (Occurrence) — Hospital Professional Liability Self-Insurance — Occurence.
HPL Self-Ins. (Claims-Made) — Hospital Professional Liability Self-Insurance — Claims-Made.

C. **DATES — Record by month, day, year.**

Injury — Record the date the injury first occurred.
Filing — Record the date the case was filed in court or arbitration.
Report — Record the date the participating organization first received notice of the injury as a possible claim.
Closure — Record the date the case is finally closed as far as your participating organization is concerned.

D. **INJURED PARTY**

Age — Enter the claimant's age on date of injury, if the age is months or days so indicate. Enter "UNK" if unknown.
Sex — Check as appropriate.
Type — Patient — any person on the premises for the purpose of receiving medical care.
Other — Any visitor, vendor, employees of contractors, etc.
Medical Expenses Paid By — Check as appropriate.

E. **RESOLUTION OF THIS CLAIM**

Method of Disposition — Check the appropriate method by which your claim is disposed of. If the claim is abandoned or voluntarily dismissed check "settled by parties."

F. **INJURY**

This section seeks information on the primary cause, location and severity of the injury to the patient.
Cause — Check the one cause which most nearly matches the primary reason why the claim was brought and/or paid.
Location — Check the one section which most nearly describes where the primary cause of patient's injury occurred.
Severity —
Emotional only — Fright, no physical damage.
Temporary-Insignificant — Lacerations, contusions, minor scars, rash. No delay.
Temporary-Minor — Infections, mis-set fracture, fall in hospital. Recovery delayed.
Temporary-Major — Burns, surgical material left, drug side effect, brain damage. Recovery delayed.
Permanent-Minor — Loss of fingers, loss or damage to organs. Includes nondisabling injuries.
Permanent-Significant — Deafness, loss of limb, loss of eye, loss of one kidney or lung.
Permanent-Major — Paraplegia, blindness, loss of two limbs, brain damage.
Permanent-Grave — Quadraplegia, severe brain damage, lifelong care or fatal prognosis.
Death —

G. **INDEMNITY AND EXPENSE PAYMENTS — Round to Nearest Dollar.**

The first two lines ask for payments made by or on behalf of the organization completing this form. No attempt is made to determine the origin of the payment. Only total expense and indemnity payments are requested.

Allocated Expenses — These expenses include attorney fees, court recorder expenses, copy fees, subpoena fees, etc.

Indemnity — These are indemnity dollars paid to the claimant directly or the cost of a structured settlement. Do not enter the yield of a structured settlement. Record the amount attributable to economic and non-economic damages.

For the Entire Case — Enter the total settlement indemnity paid to claimant, including the indemnity previously reported as paid by or on behalf of this organization. If the total is unknown or the case is not completely settled enter "UNK".

Case Closed Against All Defendants — Check yes or no as appropriate.

Answer Only if Indemnity Was Paid On Behalf Of Hospital — This series of three questions is intended to determine the involvement of the staff physicians, residents and/or interns in cases involving payment on behalf of a hospital. Complete as indicated.

Answer Only If One Or More Codefendants Was Uninsured — This question is intended to determine if uninsured organizations or individuals are participating in claim settlements.

This form is to be completed in compliance with Public Act 173 of 1986. Failure to complete is a violation of Section 438 of Public Act 218 of 1986, the Insurance Code.

Send completed form to:

Medical Malpractice Reporting
Michigan Insurance Bureau
P.O. Box 30220
Lansing, MI 48909

LIST OF COUNTIES

1	ALCONA	22	DICKINSON	43	LAKE	64	OCEANA
2	ALGER	23	EATON	44	LAPEER	65	OGEMAW
3	ALLEGAN	24	EMMET	45	LEELANAU	66	ONTONAGON
4	ALPENA	25	GENESEE	46	LENAWEE	67	OSCEOLA
5	ANTRIM	26	GLADWIN	47	LIVINGSTON	68	OSCODA
6	ARENAC	27	GOGEBIC	48	LUCE	69	OTSEGO
7	BARAGA	28	GRAND TRAVERSE	49	MACKINAC	70	OTTAWA
8	BARRY	29	GRATIOT	50	MACOMB	71	PRESQUE ISLE
9	BAY	30	HILLSDALE	51	MANISTEE	72	ROSCOMMON
10	BENIZE	31	HOUGHTON	52	MARQUETTE	73	SAGINAW
11	BERRIEN	32	HURON	53	MASON	74	SANILAC
12	BRANCH	33	INGHAM	54	MECOSTA	75	SCHOOLCRAFT
13	CALHOUN	34	IONIA	55	MENOMINEE	76	SHIAWASSEE
14	CASS	35	IOSCO	56	MIDLAND	77	ST. CLAIR
15	CHARLEVOIX	36	IRON	57	MISSAUKEE	78	ST. JOSEPH
16	CHEBOYGAN	37	ISABELLA	58	MONROE	79	TUSCOLA
17	CHIPPEWA	38	JACKSON	59	MONTCALM	80	VAN BUREN
18	CLARE	39	KALAMAZOO	60	MONTMORENCY	81	WASHTENAW
19	CLINTON	40	KALKASKA	61	MUSKEGON	82	WAYNE
20	CRAWFORD	41	KENT	62	NEWAYGO	83	WEXFORD
21	DELTA	42	KEWEENAW	63	OAKLAND		

CLOSED CLAIM REPORTING FORM

FORM B
IBA-210 (8/86)

A. **IDENTIFICATION**

01-24 INSURED'S/DEFENDANT'S NAME

31

1. Primary Defendant
2. Secondary Defendant

25-30 LICENSE NUMBER

32-36 COMPANY CODE

37-49 COURT OR ARBITRATION NUMBER

50-51 COUNTY CODE NO.

52-75 PLAINTIFF'S NAME

B. **COVERAGE**

76

1) HPL/PHY (occurence)
2) HPL/PHY (claims made)
3) HPL Self-insurance (occurrence)
4) HPL Self-insurance (claims made)

C. **DATES**

77-82 INJURY

83-88 FILING

89-94 REPORT

95-100 CLOSURE

D. **INJURED PARTY**

101-102 AGE

103 SEX 1 Male 2 Female

104 TYPE 1 Patient 2 Other

105 MEDICAL EXPENSE PAID BY

1) Medicare 2) Medicaid
3) Health Insurance
4) Other 5) Unknown

E. **RESOLUTION OF THIS CLAIM**

106

1) Settled by mediation
2) Settled by parties
3) Trial verdict
4) Arbitration

F. **INJURY**

107-108

1) Anesthesia accident
2) Blood transfusion
3) Consent issues
4) Delay in diagnosis
5) Delayed/refused treatment
6) Equipment failure
7) Fall
8) Medication error
9) Misdiagnosis
10) Misidentification of patient
11) Surgery technique
12) Surgery unnecesssary
13) Treatment technique
14) Treatment unnecessary
15) Obstetrical procedure
16) Vicarious liability
17) All other

LOCATION

109-110 [ ][ ]

1) Critical care unit
2) Emergency room
3) Labor & delivery room
4) Nursery/Peds
5) Operating suite
6) Patient's room
7) Physical therapy dept.
8) Physician's office
9) Radiology
10) Recovery room
11) Special procedure room
12) Other

SEVERITY

111-112 [ ][ ]

1) Emotional only
2) Temp. insignificant
3) Temp. minor
4) Temp. major
5) Perm. minor
6) Perm. significant
7) Perm. m
8) Perm. grave
9) Death

G. **INDEMNITY AND EXPENSE PAYMENTS**

113-119 [ ][ ][ ][ ][ ][ ][ ] ALLOCATED EXPENSES: PAID BY AND/OR ON BEHALF OF THIS DEFENDANT INCLUDING DEDUCTIBLE, COPAY, EXCESS

120-126 [ ][ ][ ][ ][ ][ ][ ] INDEMNITY: PAID BY AND/OR ON BEHALF OF THIS DEFENDANT INCLUDING DEDUCTIBLE, COPAY, EXCESS

127-133 [ ][ ][ ][ ][ ][ ][ ] AMOUNT ATTRIBUTABLE TO ECONOMIC DAMAGES

134-140 [ ][ ][ ][ ][ ][ ][ ] AMOUNT ATTRIBUTABLE TO NON-ECONOMIC DAMAGES

141-147 [ ][ ][ ][ ][ ][ ][ ] INDEMNITY FOR ENTIRE CASE: PAID BY ALL PARTIES FOR ALL DEFENDANTS IF KNOWN

148 [ ] 1 = YES 2 = NO CASE CLOSED AGAINST ALL DEFENDANTS?

Answer only if indemnity was paid on behalf of hospital
1 = Yes, 2 = No

149 [ ] 1) WAS INDEMNITY PAID ON BEHALF OF THE HOSPITAL PRIMARILY THE RESULT OF ALLEGED NEGLIGENCE OF A PHYSICIAN, RESIDENT, OR INTERN?

150 [ ] IF THE ANSWER TO NO. 1 IS YES, WAS HE/SHE EMPLOYED BY THE HOSPITAL?

151 [ ] IF THE ANSWER TO NO. 1 IS YES, WAS HE/SHE COVERED UNDER THE HOSPITAL'S POLICY?

Answer only if one or more of codefendants was uninsured

152-159 [ ][ ][ ][ ][ ][ ][ ][ ] AMOUNT PAID BY UNINSURED CODEFENDANT(S) IF KNOWN?

DATE _____ PERSON RESPONSIBLE FOR REPORT _____ TELEPHONE NUMBER _____